Beyond The Plan

Add value to your strategic plan by making team building and education part of the process.

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The refrain in oncology care is all too familiar: shrinking reimbursement, escalating costs, and increased demand for cancer care from an aging population. Add to these issues the pressures of healthcare workforce shortages, constant changes in reimbursement rules and regulations, and the ongoing restructuring of the Medicare program, and strategic planning for your cancer program may feel like scaling a mountain during an earthquake. You know where you want to go, but finding the best route is problematic.

In the past, hospitals and physicians addressed these pressures through internal efforts—continually looking for ways to streamline operational processes and to attract more patients (and more revenue). Today, those tactics are simply insufficient.

For hospital-based cancer programs, strategic planning has never been more important or offered a wider range of innovative options. But merely adding volumes, services, or programs are no longer enough to guarantee survival. In fact, we would go one step further: The oncology community, as a whole, can no longer afford to develop and implement separate strategic plans for hospitals and private practices. For 2006 and beyond, oncology providers, whether hospital or practice based, must accept that planning strategies today require a team approach—united we stand. Cooperation, collaboration, and alignment are the cornerstones for building strategies that will allow *all* of the stakeholders to survive. In other words, strategic planning for the future needs to stem from relationships and common goals, shared interests and mutual support.

Strategic Planning Defined

Despite the fact that numerous books, articles, and presentations have attempted to define and outline strategic planning, we never seem to get the definitive answer. We believe most attempts fall short because most strategic planning projects fail to capture the full potential value of the process. "Strategic planning" becomes so focused on the end product—"The Plan"—that often the rich value of the "process" is overlooked.

Yes, strategic planning should address high-level issues, including the "big picture" direction for the cancer program. But often strategic plans *only* do this: state the obvious and remain vague and difficult to use in any mean-

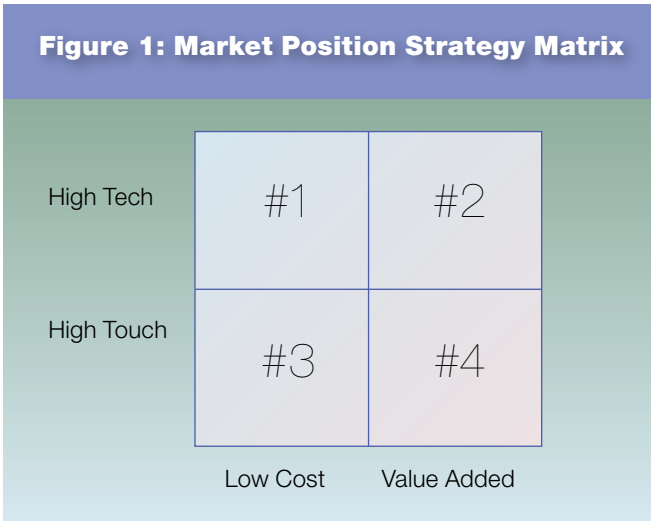
ingful way. We have even seen cancer programs develop strategic plans almost solely for the purpose of obtaining a nod of "legitimacy" for the program from the Board.

A strategic planning project can and should be much more. If the final "Plan" is your program's guide toward its summit goal—the strategic planning *process* is an unparalleled opportunity for education and team building. For community cancer centers, strategic planning can add value by strengthening your program, aligning objectives, increasing communication, and fostering a supportive collaborative environment. We see strategic planning as a round-trip adventure, starting with a "top down" validation of high-level considerations, moving to a "bottom up" effort to gather and interpret information (regional and national trends, marketing information, and financial data), and ending again at the top with a fully informed outline of the strategic priorities and initiatives necessary to achieve the validated mission and vision.

High Tech vs. High Touch

Whether articulated or not, every institution has an overarching positioning strategy. For most hospitals, this strategy falls somewhere in the market position strategy matrix (see Figure 1) where the *y* axis indicates the degree to which the institution relies on sophisticated technology versus a high level of personal caring as the platform for market differentiation. This approach is often called "high tech vs. high touch." For example, in markets where small community hospitals compete with large academic institutions, university-affiliated programs generally play up their equipment and technological expertise while community hospitals often promote their mission of compassionate care.

Figure 1: Market Position Strategy Matrix



The *x* axis is, in truth, a financial measure. Some institutions seek to gain dominance and patient loyalty by positioning themselves as the best economical choice. Others will focus on the added value that a full menu of services brings (with the unspoken assumption that quality is not cheap).

When constructing a strategic plan for cancer services, the team must know where the larger organization fits within this matrix. Obviously, few (if any) institutions are likely to attain significant success positioned in box #1 (high technology/low cost). The costs of leading-edge technology simply do not allow for the institution to also be the low-cost provider in the market. Similarly, institutions aiming to position themselves in box #3 (high touch/low cost) will probably not be able to support a strategic plan that focuses on early adoption of emerging technology. An important first step for the cancer center's strategic planning team is to understand and accept this overall positioning issue or their efforts may be wasted.

Unfortunately, we have seen dozens of strategic plans fail because this basic tenet of market position alignment went unrecognized. Often, this occurs because trust and communication problems exist between physicians and the hospital. Each side ends up feeling that the other side "just didn't listen" or "just didn't care." Regaining mutual trust is a time consuming and sometimes painful process. Cancer centers will find it much easier to craft a viable strategic plan when all parties are relatively comfortable with each other and their goals and interests are in relative alignment.

Physician and Hospital Alignment

Once the overarching market position strategy is clearly understood, the team needs to ensure alignment within the cancer program itself. For example, if the physicians' main concern is financial stability, the hospital's programs and services should be structured in a manner that does no harm to the practices—and vice versa.

Over the past few years, constant reimbursement pressures on providers in all settings have brought physician/hospital alignment issues to the forefront. The oncology community has seen a steady and rapid rise in requests to bring both parties (physicians and hospital management) to the table to discuss alignment strategy.

Physician/hospital alignment issues that may need to be addressed include:

- Specific agreements regarding competing businesses
- Joint investment in new organizational entities and facilities
- Shared ownership and governance models

- Merged practices
- Practice acquisitions
- Contractual arrangements for various services
- Physician employment.

Decisions regarding these alignment options are influenced by a wide variety of factors including cultural and philosophical considerations, tolerance for risk (and the definition of "risk"), financial positions, willingness to handle complex relationships, and, of course, legal hurdles.

Having achieved solid alignment from the top down, the strategic planning team is now ready to gather three major types of information—*trends*, *market*, and *finance*. The team members must understand the information gathered and accept the information as valid. Otherwise, the strategic plan will simply become a "wish list" of services, programs, and equipment based on individuals' interests and not on a balanced view of the local reality.

Trends, Trends, and More Trends

The strategic planning team needs to examine global, national, and regional trends to formulate a clear picture of the environment for which they are planning. Trending data serves to inform virtually all aspects of the strategic plan, including: marketing, staffing, space, support services, reimbursement, and technology.

Identifying outside resources for the strategic plan is also critical. Numerous tools are available to the strategic planning team, including resources from the government, professional associations, societies and foundations, and advocacy groups (see pages 32-33).

Using these resources, the team can:

- Identify marketing and planning data
- Develop staffing models, which include physicians, nursing, radiation oncology professionals, pharmacists, social workers, and radiology staff
- Find assistance in planning for space design, facility construction, and equipment purchasing needs
- Establish supportive services, such as patient and family services, nutrition, and survivor programs
- Improve reimbursement for cancer care
- Provide guidance on business and information technology systems.

Because each of these areas can be complex and difficult to plan for, the team should use all available resources.

Marketing Strategy

Next, the strategic planning team can focus on examining the local market. (Note: In this context, marketing is *not* the same thing as advertising, although advertising and promotion plans will be incorporated in some manner in the strategic plan.) For the purposes of this article, marketing is defined as four core activities that determine: 1) the size of the market, 2) the share of that market currently being captured, 3) the elements that can achieve an increase in share, and 4) the estimated cost to increase that share.

First, the strategic planning team must determine *where* the services will be provided. Throughout the region? Across the county? Within one or two towns? In a particular neighborhood?

Next, the strategic planning team needs to determine which services are currently available in the market, looking for oversupply or gaps. This exercise helps to identify any specific demands for the services. Once the team sees a particular "demand," the next step is to quantify that demand. Cancer is a unique disease in that it is primarily treated in the outpatient setting. This characteristic makes quantifying existent utilization somewhat difficult. Fortunately for marketers, cancer has been a reportable disease since 1972, and cancer registrars are charged with tracking the disease and following the patients for the duration of their lives.

To measure your current market share, you need to know how many cancer cases (preferably categorized by age, sex, and disease site) were seen and treated by your program in defined time periods (past years, quarters, months, etc.). Dividing these numbers by the total

7 Keys to a Successful Marketing Plan

- Know your local market, including your competitors and your patients.
- Identify where your cancer services are provided.
- Understand the services currently available in the market and look for oversupply or gaps in services.
- Compute your cancer center's current market share.
- Develop an appropriate marketing strategy whether "defensive" (to stave off market incursion) or "offensive" (to grow the program and increase market share).
- Decide what the cost per percentage point will be (in dollars) for market growth.
- Review all marketing options (advertising, sponsored activities, educational offerings, etc.) and know which customers you are going after (individuals with cancer, family members, referring physicians).

Defining and Measuring Cancer Services

Community cancer centers usually "define" cancer services in one of three ways: by cost center, by DRGs, or by ICD-9 codes. As you will see, pros and cons exist for all methods.

Cost Centers

Traditionally, cancer centers use the volumes and revenues from specific cost centers to analyze the success or failure of their programs. Historically, these cost centers included the operating room, radiation therapy, and infusion services, as well as inpatient units. (The problem with including inpatient beds is that many are not dedicated solely to cancer patients.)

This methodology has two advantages. First, specific volume and revenue are credited to the cancer program. Second, both inpatient and outpatient activity is captured. On the negative side, this methodology shows only a narrow representation of the cancer program and does not factor in the impact of cancer services on other cost centers (i.e., pathology, radiology, laboratory, other inpatient units, etc.)

Diagnosis-Related Groups (DRGs)

This methodology captures all charges for services rendered during patient admission (OR, radiology, infusion, pathology, etc.) and allows market share comparison for cancer programs in states that have an inpatient (IP) data warehouse. Using DRGs to "define" and "measure" your cancer services has one major weakness: the data are isolated to hospital data only and do not capture outpatient activity. Since cancer care is provided primarily in the outpatient setting, this may not be an optimal choice for your cancer program. Similar to the cost center methodology, DRGs also offer a narrow representation of the cancer program.

ICD-9 Codes

The International Classification of Diseases Version 9 (ICD-9) methodology uses a diagnosis code range (140.0 to 239.9) to define cancer center services. Any volume, charges, and revenue tied to a diagnosis code within this range are counted as part of the cancer program profile. Defining and measuring your cancer services this way provides a true representation of all the services used/impacted by the cancer program. The main advantage with this method is that *all* charges for inpatient and outpatient services rendered to a patient are captured. The methodology is not without its weaknesses, however. For example, it is difficult to compare market share due to lack of valid outpatient data. In addition, these can be very difficult data to extract from some data systems. Another drawback: others in the organization may see this definition as an "overstatement" and may believe that the downstream revenue should not be credited to the cancer program.

number of cases in the geographic area defined above will provide your market share. Market share can be identified for virtually any patient population—limited only by the extent of detailed data available for that geographic area.

If your "market share" number approaches 100 percent, your planning team will likely develop a more "defensive" strategy for certain programmatic areas that will aim to stave off market incursion rather than achieve growth. On the other hand, if your market share is less than 100 percent, strategic decisions are more likely to focus on topics such as which programs are in demand and what is the likely cost to develop those programs to capture additional share.

At this point, the strategic planning team needs to decide the cost per percentage point. In other words, to move from 50 percent of the market to 51 percent—what is the cost in dollars? For markets with multiple players (cancer centers), the acceptable cost per point may be small. Cancer centers that have one only major competitor—meaning the odds for success may be improved—may decide that a higher financial risk is acceptable.

Once the cost per point is determined, the next decision is: *How can we increase market share*? This question can be answered many ways—through advertising, name awareness of service offerings, activity sponsor-

"Higher" Quality of Care May *Not* Differentiate Your Program

For the oncology community, the most frequently attempted differentiation element is quality. Unfortunately most, if not all, cancer centers believe they provide the highest quality of care.

In reality, only cancer centers that have a quantifiable way to demonstrate a higher quality of care should rely heavily on this angle. For example, an audit against a set of recognized quality standards can provide "proof of quality." Other opportunities for such proof include surveys and accreditations by organizations like the Joint Commission on Accreditation of Health Care Organizations, the American College of Surgeons Commission on Cancer, or the American College of Radiology. Keep in mind, if your competitor is also accredited by these groups, there is little differentiation in terms of quality of care—short of attempting to publicize clinical outcomes—which is a topic far too large to incorporate in this article.

Resources for the Strategic Planning Team

Governmental

Centers for Medicare & Medicaid Services (CMS, *www.cms.hhs.gov*) is a federal agency within the U.S. Department of Health and Human Services (HHS). Some services include chart and slide shows showing key features of CMS, statistical analysis for researchers and healthcare professionals for a broad range of quantitative information, reimbursement, future Medicare and Medicaid spending, healthcare industry market updates, and consumer information.

National Cancer Institute (NCI, *www.cancer.gov*) coordinates the National Cancer Program, which conducts research, training, health information dissemination, and other programs with respect to diagnosis, prevention, and treatment of cancer, as well as rehabilitation from cancer. Among the resources offered are support and coordination of research conducted by universities, hospitals, research foundations, and businesses across the U.S. and abroad; training in clinical disciplines; support for a national network of cancer centers; and collection and dissemination of information on cancer.

Surveillance, Epidemiology, and End Results Program (SEER, *www.seer.cancer.gov*) of the NCI is an authoritative source of information on cancer incidence and survival in the United States. SEER began collecting data on cases on January 1, 1973, and currently collects and publishes cancer incidence and survival data from 14 population-based cancer registries and three supplemental registries covering approximately 26 percent of the U.S. population. Information on more than 3 million in situ and invasive cancer cases is included in the SEER database, and approximately 170,000 new cases are added each year within the SEER coverage areas. The SEER Registries routinely collect data on patient demographics, primary tumor site, morphology, stage at diagnosis, first course of treatment, and follow-up for vital status. The SEER Program is the only comprehensive source of population-based information in the United States that includes stage of cancer at the time of diagnosis and survival rates within each stage.

Centers for Disease Control and Prevention (CDC, *www.cdc.gov*) is one of the 13 major operating components of HHS. CDC compiles statistical information from birth and death records, medical records, interview surveys, and through direct physical exams and laboratory testing, providing credible information to enhance health decisions, and promoting health through strong partnerships.

Professional Associations

Association of Community Cancer Centers (ACCC, *www.accc-cancer.org*) is a national multidisciplinary organization that defines quality care for patients with cancer. ACCC membership includes more than 600 hospital-based cancer centers, freestanding cancer centers, and physician practices and includes physicians, nurses, administrators, and other oncology professionals. Programs include: cancer program management, reimbursement issues, insurance benefits to patients, national policies, and patient advocacy.

American College of Surgeons Commission on Cancer (ACS, *www.facs.org/cancer/cancermenu.html*) is an accrediting program for community cancer programs. There are 1,431 approved programs across the U.S. Programs include: development and approval of cancer programs, cancer liaison program, educational activities, National Cancer Data Base.

American Society of Clinical Oncology (ASCO, *www.asco.org*)

ships, and well-publicized education offerings, among others. As you review each option, keep in mind that there is more than one customer to be attracted. The most *obvious* customer is the potential patient and his or her family members, but the most *important* customer may be the potential referring physician. These audiences are very different and they need to be approached in different ways.

In particularly competitive markets, a community-oriented marketing strategy can be quite effective. Consider sponsoring high-visibility support groups or educational outreach programs aimed not only at the immediate potential patient audience, but their children or grandchildren as well. For example, your cancer center could sponsor a poster contest for school-age children on the hazards of tobacco use. The winning poster becomes a billboard (with the hospital's logo on it).

Whatever plan is implemented, the strategic planning team must monitor the cost per percentage point of market share gained. This means *frequent* measurement. Without measurement, the cancer center may waste valuable dollars on high-cost new programs or on expensive promotional activities (e.g., radio, television, and billboard ads) that are simply not working.

At the end of the day, the strategic planning team must create marketable points of differentiation and develop marketing plans that establish an awareness of services and the salient points of *differentiation*—regardless of the target audience (also see box on page 31). Much of the strategic planning team's work should focus on the cancer center's programs, services, and offerings that serve the community's unmet needs or wants—not as perceived by the team—but as proven by the market and trend data discussed above.

Developing a Comprehensive Financial Summary and Program Profile

Numbers can mean everything…or nothing. The numbers' strength depends on the underlying methodology used to gather the cancer program's financial information (see page 31). A full accounting of all volume and financial metrics is absolutely necessary to understand the full spectrum of the cancer program and to develop a successful strategic plan. When compiling monthly,

represents more than 21,500 members from more than 100 countries representing all oncology disciplines and subspecialties. Programs include improving patient care and prevention, advancing the education of physicians and other professionals, fostering communication between cancer-related disciplines, and advocating public policy.

Oncology Nursing Society (ONS, *www.ons.org*) represents more than 32,000 registered nurses and other healthcare providers dedicated to excellence in patient care, education, research, and administration in oncology nursing. ONS services include information and education around the world, active role in advocacy activities at the local, state, national, and international levels.

American Society of Therapeutic Radiology and Oncology, (ASTRO, *www.astro.org*) represents more than 7,500 members including radiation oncologists, radiation oncology nurses, medical physicists, radiation therapists, dosimetrists, and biologists. The membership comes from hospital programs and freestanding centers. ASTRO's mission is to advance the practice of radiation oncology. Programs include education, healthcare economics, governmental relations, and research.

American Society of Hematology, (ASH, *www.hematology.org*) represents 13,000 members from around the world. ASH's mission is to further the understanding, diagnosis, treatment, and prevention of disorders affecting the blood, bone marrow, and the immunologic, hemostatic and vascular systems. The association promotes research, clinical care, education, training, and advocacy.

Other associations that may be of assistance include:

- National Comprehensive Cancer Network (NCCN, *www.nccn.org*)
- Association of Oncology Social Work, (AOSW, *www.aosw.org*)
- American Society of Health-System Pharmacists, (ASHP, *www.ashp.org*)
- Society for Radiation Oncology Administrators (SROA, *www.sroa.org*)
- Association of Cancer Executives, (ACE, *www.cancerexecutives.org*)
- The Advisory Board – Oncology Roundtable, (*www.advisoryboard-company.org*)
- American Association for Cancer Research, (AACR, *www.aacr.org*)
- The Association of American Cancer Institutes (AACI, *www.aaci-cancer.org*)
- American Hospital Association (AHA, *www.aha.org*).

Societies and Foundations

The America Cancer Society (ACS, *www.cancer.org*) is a national community-based voluntary health organization dedicated to the elimination of cancer as a major health problem.

Other societies include: The Leukemia and Lymphoma Society (*www.leukemia-lymphoma.org*) and Susan G. Komen Foundation (*www.komen.org*).

Advocacy Groups

Cancer advocacy groups have become well organized and can be useful sources of information for patient and research activities. A sampling includes The National Coalition for Cancer Survivorship, (*www.cansearch.org*), National Patient Advocate Foundation, (*www.npaf.org*), and Friends of Cancer Research, (*www.focr.org*).

From these sources, the planning team can learn about the current state of the art and emerging trends in technology and science (drugs, equipment, genetics, information systems, etc.); cultural and social issues (complementary medicine, attitudes towards care among specific populations, etc.); financial and reimbursement trends (costs of new technology, equipment, drugs; payer attitudes and pressures, etc.); demographic and societal factors (population age and race, insurance mix, workforce availability, etc.).

quarterly, and annual reports, you need to chose and carefully structure the methodology for gathering data. Otherwise, you run the risk of short-changing the cancer services financial profile and making critical program decisions on an incomplete financial summary.

While defining the scope of the cancer program is crucial to the strategic planning process, the cancer program's profile should be based on other (carefully determined) business measures including:

- Patient discharges
- Inpatient length of stays
- Outpatient encounters
- Units charged
- Patient charges and collections
- Direct and indirect program costs
- Contribution margin
- Net income
- Collection rate
- Payer mix.

These measures are just a few of the multitude of data variables available in most healthcare information systems. Most commonly used in program review and analysis are the following:

Inpatient discharges are the numeric count of the total discharges that occurred for the designated time frame. Identifying this number for the cancer program and comparing it to the hospital's total discharges can provide an understanding of the percent of total business that is generated by the cancer program. It also can provide the necessary data to calculate market share if the state has an accessible inpatient data warehouse. One item to understand is how the particular institution categorizes observation patients—those who stay overnight (typically less than 24 hours) but are never admitted to an inpatient unit.

Outpatient encounters are the total number of single outpatient events per cost center. So, for example, a patient that went to radiology, the infusion center, and the laboratory on the same day would generate three distinct encounters—regardless of the units charged at each outpatient venue. This measure provides a true sense of the magnitude of resources used in the outpatient setting and from areas/cost centers not typically defined as part

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of the cancer program. For department heads and directors, this information is extremely helpful when projecting cancer program growth.

Charges refers to the total amount billed to payers and/or patients for services rendered.

Collections are the amount of money paid to the hospital from third party payers and patients for services that were rendered.

Contribution Margin is the direct cost subtracted from the collected amount.

Net Income usually includes indirect costs and provides the amount of revenue generated by the cancer program. This is a measure of profitability of the program.

Payer Mix shows the blend of insurance coverage for the cancer program's patient population. Each insurance plan or payment option is grouped into one of several larger categories (i.e., commercial, managed care, Medicare, Medicaid, self pay) with a measurement of the percent of total calculated for each broad category. Payer mix can be measured for any of the financial measures listed above.

Once the strategic planning team identifies the most important measures, the next critical step is to work in collaboration with the Information Technology (IT) department to setup a systematic data run of these variables on a pre-determined schedule (weekly, monthly, quarterly). These regular reports show the growth or reduction of the cancer program and provide a deeper understanding of the program's true profitability.

Remember: A clear, sound methodology for defining cancer care backed by corresponding financial measures gives the strategic planning team the necessary information to make appropriate business decisions.

Bringing the Strategic Plan Together

Engaging the strategic planning team members in the collection of the necessary data (see above) achieves maximum value. When team members participate in the research, their comprehension and their commitment can increase dramatically. Unfortunately, team members often do not have enough time, motivation, and/or guidance to take on this work. Your cancer center might choose to contract with an external resource, such as a consulting firm, to collect this data. Or maybe another staff member within the organization will have the time and expertise to undertake the research. Whatever option you choose, the greater the depth of the teams' understanding, the more valuable the interactions and the better the end product will be.

In fact, the value of bringing a number of stakeholders to the table in facilitated conversation cannot be underestimated. Questions and answers must be encouraged, and team leaders should be prepared to help team members validate data. Consider inviting upper management (CEOs, COOs) to attend at least the meetings in which the cancer center research is discussed. This participation will increase the strategic planning team's credibility, and will likely lead to better visibility and stronger support from the "top" of the organization. Over the course of the planning process, the team should ask and answer the following questions:

Who and what do we want our mission and vision to be?
- How should we align?
- What kind of services should we provide?
- What should our market position be?

What do we need in order to achieve our mission/vision?
- Is there sufficient demand and potential value?
- What approximate costs/resources will we need?
- What is our estimated timeline?
- What order and priority do we give the elements of our plan?

Your final strategic plan will summarize not only the process leading to these answers, but also the process to move forward. Initiatives requiring additional investigation (e.g., full business planning) will be identified, and all initiatives will be tentatively prioritized for both importance and timing. The strategic plan will have defined 1) the required resources, 2) implementation responsibilities, and 3) follow-up measures and mechanisms.

Although many strategic plans are beautifully crafted, far too few come to life. Even with all the above components articulated and communicated throughout the organization, if key stakeholders and program champions are not properly engaged, they will have no commitment to support follow through. The *only* way to guarantee a successful strategic plan is to seize the value of the process—the opportunity for team building based on shared knowledge, information, and goals. In the end, that process is far more valuable than any resulting paper or electronic document.

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